

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize Gulf Coast Mental Health to use or disclose the following protected health information (PHI) from the medical records of the patient listed below to:

Requestor Name: Dukes, Dukes, Keating and Faneca, P.A.
P.O. Drawer W
Gulfport, MS 39502

Patient Name: Marguerite Carrubba
Patient DOB: [REDACTED]
Patient Social Security Number: [REDACTED]
Patient Address: c/o Robert G. Harenski, Esquire
1906 Pass Road
Biloxi, MS 39531

Disclose the following PHI for treatment dates [REDACTED] to Present.

☒ Abstract/Pertinent ☒ History and Physical ☒ Physician Orders ☒ Entire Chart
☒ Operative Report ☒ Progress Notes ☒ X-ray ☒ Billing
☒ ER Report ☒ Lab ☒ Consult
☒ Other specified ☒ Discharge Summary ☒ Nurse Notes
☒ Other Specified: All other such records in your possession, custody or control.

The above information is disclosed for the following purposes:

☒ Medical Care ☒ Legal ☐ Insurance ☐ Personal ☐ Other

MC
initials

I acknowledge, and hereby consent to such, that the release of information may contain alcohol and drug abuse, psychiatric, HIV or genetic information

This authorization shall expire upon this expiration date: final disposition of Marguerite Carrubba or five (5) years from the date of this authorization, whichever comes first

**If I fail to specify an expiration date or event, this authorization will expire six (6) months from the date on which it was signed.

- I understand that I have the right to revoke this authorization at any time. I understand that I must do so in writing and present the written revocation to: Gulf Coast Mental Health. I understand that the revocation will not apply to information that has already been released to this authorization.
- The information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected.

I have read the above and authorize the disclosure of the protected health information as stated. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.

Marguerite Carrubba
Signature of Patient/Legal Representative

2/5/09
Date

If signed by legal representative, relationship to patient: _____

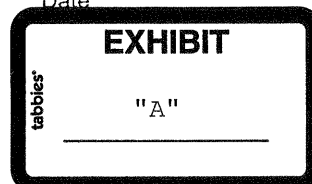
Signature of Witness

Date

If signed by legal representative, relationship to patient: _____

Signature of Witness

Date



SWORN TO AND SUBSCRIBED BEFORE ME, this the 5th day of February, 2009.

Lana M. Pease
NOTARY PUBLIC

My Commission Expires:

1-13-2012

This authorization is designed to be in compliance with the Health Insurance Portability and Accountability Act ("HIPAA") 45 CFR Parts 160 and 164.

NOTARY PUBLIC
ID No. 34711
My Comm Expires
Jan 13, 2012

HARRISON COUNTY
STATE OF MISSISSIPPI

AUTHORIZATION FOR RELEASE OF PSYCHOTHERAPY NOTES

Name: Marguerite Carrubba

Date of birth: [REDACTED]

Social Security Number: [REDACTED]

I hereby authorize all health care providers, physicians, hospitals, clinics and institutions, medical facilities, mental health clinics, mental health hospitals, pharmacies, Social Security Administration Disability Determination Services and Department of Workers' Claims, to release all psychotherapy note records and information regarding Frances Winn, to the records service of Cy Faneca, Dukes, Dukes, Keating and Faneca, P.A., P.O. Drawer W, Gulfport, MS 39502.

I understand that this authorization is for release of psychotherapy notes as defined by the Health Insurance Portability and Accountability Act 45 CFR 164.501 [psychotherapy notes means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's record].

I, the undersigned individual am on notice that:

- Initiating this request for disclosure of protected health information, and any disclosure of the same pursuant hereto is at the request of the individual.
- Any health care provider disclosing the above requested information may not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs this authorization.
- This authorization can be revoked through written notice to Frances Winn, or to the individual above listed entities, except to the extent that action has been taken in reliance on this authorization. The undersigned is aware of the potential that protected health information disclosed pursuant to this authorization is subject to re-disclosure in a manner that will not be protected by HIPAA regulations.
- A photocopy of this authorization shall be considered as effective and valid as the original, and this authorization will remain in effect until settlement or final disposition of **William David Seal v. Harrison County, Mississippi, et al.** or five (5) years from the date of this authorization, whichever comes later.

I have carefully read and understand the above, and do herein expressly and voluntarily authorize the disclosure of the above information about, or medical records of, my condition to those persons or agencies listed above.

Date:

2-5-2009

(Signature) Parent or Patient Representative

Marguerite Carrubba

Printed Name of Patient's Representative

Relationship to Patient

Description of Representative's Authority to Act for the Patient

SWORN TO AND SUBSCRIBED BEFORE ME, this the 5th day of February, 2009.

NOTARY PUBLIC

My Commission Expires:

1-13-2012



This authorization is designed to be in compliance with the Health Insurance Portability and Accountability Act ("HIPAA") 45 CFR Parts 160 and 164.

*Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress date.